**NEBRASKA PUBLIC HEALTH LABORATORY**
UNIVERSITY OF NEBRASKA MEDICAL CENTER
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# SPECIAL MICROBIOLOGY REQUISITION

**PATIENT LAST NAME** **FIRST NAME** **MI**

**SUBMITTED BY:**
Name : _____
Address: _____
_____
Phone: (____)____-_____
Fax: (____)____-_____
UPIN No.: _____

**Test approved by: _____**
**v. 2015**

**DATE OF BIRTH** **AGE** **SEX**
__/__/__ M / F

**ADDRESS** **APT**

**CITY** **STATE** **ZIP**

**COUNTY CODE** **STATE CODE** **SURVEILLANCE SITE**

**PHYSICIAN'S NAME** **PHONE #**

**COLLECTION DATE** **COLLECTION TIME**
__/__/__ **AM / PM**

**ID / CHART NUMBER (NUMBER WILL APPEAR ON REPORT)**

**Clinical Diagnosis:**_____ **ICD 9 Code:**_____

**Race** ___White ___Black ___Native American ___Asian/Pacific Islander ___Unknown ___Other_____

**Ethnicity** ___Hispanic ___Non-Hispanic ____Unknown

**Source:** _____Bronchial Aspirate _____CSF _____Genital _____Nasopharyngeal _____Sputum _____Stool _____Throat _____Urine _____Blood _____Other _____

**_____West Nile Virus IgM Capture ELISA (CSF)**

***Serum must be accompanied by CSF to be run at public health expense.***

**_____West Nile Virus IgG/IgM Capture ELISA Acute (serum)**

**CSF Submitted: Yes / No**

**CSF Previously Submitted: Yes / No**

**_____West Nile Virus IgG/IgM Capture ELISA Convalescent (serum)**

**CSF Previously submitted: Yes / No**

**Acute Serum IgG/IgM Previously Submitted: Yes / No**